

The Influence of Culture & Traditions on Health Behaviour In Rural India

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**THE INFLUENCE OF CULTURE AND TRADITIONS
ON HEALTH BEHAVIOUR IN RURAL INDIA**

MARCH 1997

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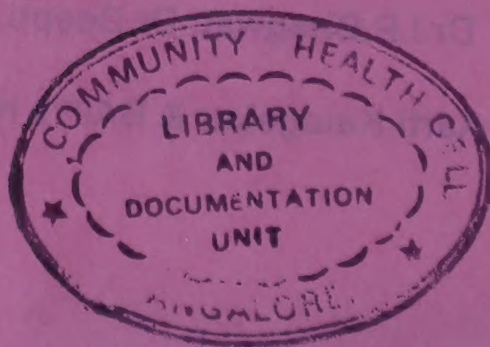
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THE INFLUENCE OF CULTURE AND TRADITIONS

ON HEALTH BEHAVIOUR IN RURAL INDIA

Executive Summary

Poverty is said to be the root cause of all disease, and integrated programmes providing both health and sustainable livelihood inputs to a community are increasingly being recommended. While improvements in socioeconomic status of families may affect their health status, does it also affect their health behaviour? This aspect was studied, as also the factors influencing health behaviour, by BAIF Development Research Foundation, a non-government organisation based in Pune, India.

A cross sectional study was undertaken by BAIF, supported by the International Health Policy Programme (IHPP), Washington DC, in the summer of 1994. The study was done in five selected rural areas of Uttar Pradesh, Rajasthan, Gujarat, Maharashtra and Karnataka states of India.

The quantitative socio-economic, demographic data was gathered with the help of structured schedules for over 3000 families from each area, and infants and preschoolers from these families were measured for their anthropometric status. Qualitative data in the form of Focus Group Sessions, Key Informant and In-depth Interviews were collected by anthropologists residing in the communities surveyed. The qualitative data focussed on health behaviour, and explained the results of the quantitative data analysis.

Our main findings were:

1. A high prevalence of malnutrition in all areas studied. The proportions of preschool children with Z-scores less than -2 SD for weight-for-age ranged between 58.5 - 73.1; that for height-for-age (stunting) between 44.1-63.7; and weight-for-height (wasting) from 21.1 to 37.6 %. The rates are particularly high in Raika, Rajasthan and Karchana, Uttar Pradesh.

THE INFLUENCE OF CULTURE AND TRADITIONS

Delayed initiation of the weaning process, after the age of one year, is the prevalent practice in all areas studied, irrespective of caste and economic class. This results in a high prevalence of severe malnutrition after six months of age, and remaining high throughout the toddler age group.

No significant gender differences were noted in the anthropometric status of girls and boys, thus showing absence of discrimination against the girl child, in any age, social or economic group.

Between 63 - 81 % of severely underweight children belong to families not reporting any food shortage. This underlines the role of culture and traditions in feeding practices.

2. An important factor contributing to the high prevalence of childhood malnutrition could be the low age at effective marriage of the girl child in all areas except Gujarat (19.2 Yr. mean). This ranged from 10.8 years in Railla, Rajasthan to 15.6 years in Akole, Maharashtra. The age at marriage was not influenced by caste or economic group, but was mainly influenced by the existing cultural norms in the areas.

Education of the girl child, even upto the primary level, was seen to be raising the age at effective marriage in all areas.

3. Breast feeding is a universal practice in all areas. However, feeding of colostrum is yet not accepted by a majority of families. Of the 242 mothers in the postnatal period during the survey, only 89 (37 %) had fed colostrum to their babies. The reasons put forward for not feeding colostrum were similar in all areas.
4. Female sterilisation is the more commonly accepted family planning method. While women are unhappy with the pills/IUDs because of their side effects, cultural reasons prevent the men from accepting vasectomy as an alternative. Of the 14225 eligible couples surveyed, 4481 women (31.5%) had accepted sterilisation, and only 515 men (3%) had accepted vasectomy.
5. Ante-, intra-, and post-natal care of women are influenced by cultural norms and traditions in all areas. A great similarity was found in foods prescribed/proscribed across the areas surveyed.

6. Traditional medicine is popular in the Karnataka, Maharashtra and Rajasthan areas surveyed. These practitioners are known for curing certain diseases, e.g., hepatitis, fractures, and people from all economic and social groups avail of their services.

The immunisation programme has been accepted by all communities in the areas surveyed. However, in our qualitative observations, we have noted the PHC Staff belonging to higher castes are reluctant to visit scheduled caste households for the purpose of implementing immunisation and other public health programmes, in Karchana, Uttar Pradesh.

Our recommendations are :

1. Considerations of cultural / traditional norms explaining health behaviour and the resultant health status, need to be a part of all health programmes. This will ensure better planning of programme inputs, and increase acceptance rates.
2. The existing cultural / traditional norms can be properly studied using ethnographic techniques. The inputs of anthropologists, especially those involving participatory appraisals, must become an important component of health programmes.
3. The continued stress on literacy, especially female literacy, must be appreciated. All efforts at promoting female literacy must be supported.
4. And lastly, increased efforts and time must be placed for health education, using culturally appropriate methods. This will help prevent cultural taboos, and increase programme success rates.

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THE INFLUENCE OF CULTURE AND TRADITIONS ON HEALTH BEHAVIOUR IN RURAL INDIA

1.0 INTRODUCTION :

The concept of health behaviour refers to the patterns of response of people regarding health problems. It studies the orientation of people toward health promotion and disease prevention practices, and their response to illness, in the form of curative care seeking behaviour (1).

Communicable diseases and malnutrition are the causes behind the majority of the health problems affecting the Indian people (2). This is especially the cause behind high infant and child mortality rates prevailing in different parts of India (3).

This scenario is a result of the interdependence / synergy of biological, environmental, behavioural and health services - related risk factors. However, the linchpin in the system is individual behaviour (4). Individuals and families must always assume ultimate responsibility for minimizing threats to personal health and for the use of available programmes and services.

India is a vast country, having a heterogenous population, diverse geographic, socio-cultural, educational, economic and infrastructural development. The major health problems listed above appear predominantly related to health behaviour in different parts of the country. It explains, for example, the high drop-out rates in immunization coverage in rural India, despite the high levels of access developed as part of the Universal Immunization Programme (UIP) of the Government of India (5). Health behaviour also explains the prevalence of moderate levels of malnutrition among children in Punjab, a prosperous state, as compared to Kerala, a state with a lower per capita income (6).

Health behaviour is a result of complex interactions between beliefs, motives, actions and environmental influences (7). But it is ultimately a result of individual / family decisions (8). Studies have been conducted on some factors influencing these decisions. These include education, cultural beliefs and traditions, communications and socio-economic status (9). These have been studied individually, or in correlation with each other, to see how they affect an important parameter like IMR (10). Studies have given varying results, depending upon the area studied (11).

That disease patterns differ between socio-economic classes is well-known (12). Little is known, however, about the role and extent of effect, of income and livelihood, on specific health behaviour (13). But income does influence health behaviour, and Rundell and Wheeler (14) have suggested income as an "alternative explanation" for the use of preventive health care.

Poverty has been said to be the "deadliest disease" (15), and the importance of poverty alleviation programmes has been stressed in order to improve the health status of the people (16). Linkages between mortality rates and poverty have been clearly demonstrated (17,18). Though the existence is well documented, the causal mechanism for the relationship is only partly understood (19).

A study was hence conducted by BAIF to document how livelihood programmes had modified health behaviour. This study was part of a health policy research on the linkages between socio-economic status and health status et behaviour, and was conducted in a cross-sectional manner across five states of India.

Since it is not just an academic observation but is associated with inequity (20), the linkage between socio-economic status and health and whether health status would improve due to poverty alleviation programme was the main objective of the present study across 5 states of India.

The hypotheses for the study were as follows :

I. General Hypotheses :

The health status and health behaviour of the rural families is largely related to their socioeconomic status.

II. Specific Hypotheses :

1. Acquired socioeconomic status improvement leads to decreased malnutrition, and reduced morbidity et mortality among women and children under five years of age.
2. The improved health status is as result of altered health behaviour in terms of :
 - a. Increased frequency of antenatal check-ups and a preference for hospital deliveries ;
 - b. Adoption of family planning methods and a preference for smaller families ;
 - c. Adoption of immunisation as a health measure ;
 - d. Use of safe water and sanitation facilities at home level ; and,
 - e. Increased age of marriage of the girl child.

The present paper describes the results obtained with regard to all hypotheses except the one concerning morbidity et mortality and immunization. These have been described separately.

2.0 MATERIALS AND METHODS :

The study was conducted in 5 states namely Karnataka, Maharashtra, Gujarat, Rajasthan and Uttar Pradesh. A sample size of 3000 families were calculated for each state, and all families in selected villages, which were contiguous, in 5 districts were included in the survey (Table 1).

Data was collected in both quantitative and qualitative manner. The quantitative data was collected using a structured schedule. Qualitative data was collected by an anthropologist residing in the area for upto 3 months by using interviews, focus group discussions and observation techniques.

The questions asked related mainly to health behaviour regarding mother and child health care. These concerned the age of marriage of women, child delivery and feeding practices, the nutritional status of children, and adoption of family planning methods.

The qualitative data was gathered to complement the quantitative data, and help interpret some of the important findings. It has been our experience that health behaviour cannot be merely explained by figures alone. Qualitative data tells us what people are doing : why people behave the way they do can be explained only by ethnographic research.

Throughout the following discussion, results of our qualitative research have been interspersed. This is to assist elucidating the figures documented in the tables.

Caste is an important cultural factor in India, and behavioural practices were also studied across caste. Caste categories were 6 in number (Table 2). Their characteristics are presented as Annexure I.

3.0 RESULTS AND DISCUSSION :

Table 1 lists the areas and the number of families surveyed in each state. Table 2 lists the caste categories of the families.

Muslims were numerically considerable only in the Uttar Pradesh survey, and were analysed separately as Caste Category 7. In other states, they have been kept in Caste Category 3.

India has a heterogenous society, and cultural practices vary widely across the country. Hence, it would be erroneous to generalise the results to entire states. The results are thus described as per the area studied in each state.

3.1 Age at Marriage of Women :

Despite a legislation in India to raise the minimum age at marriage to 18 yrs. for girls, the study showed that child marriage, i.e. effective marriage before the age of 18 is still prevalent in rural areas. (Table 3) This was analysed for all ever-married women. The usual practice in all areas except Gandevi, is to marry the girl off when she attains puberty. Reasons are cultural, and range from issues like further security of the girl, to her status. What she will do with further education is a question commonly posed in Railla and Karchana.

The importance of "Kanyadaan", i.e. marriage before a girl attains puberty, was mentioned by the upper castes in Karchana. It is believed that her father earns the Gods' blessings with this act.

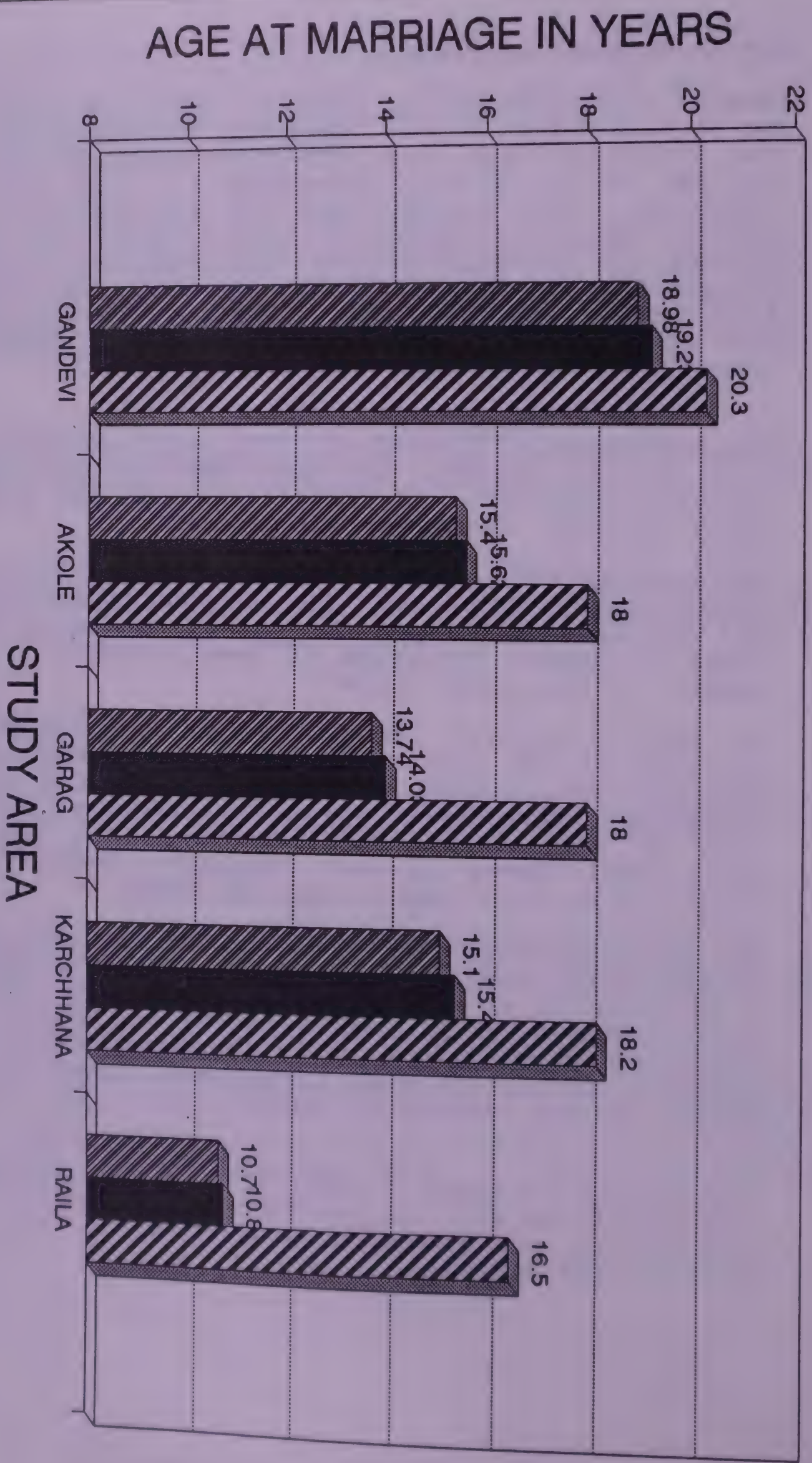
The area studied in Gandevi, however, showed signs of urbanization. Culturally, they are not conservative and are open to change. Being well connected with towns / cities, diffusion of some cultural traits appears to have taken place.

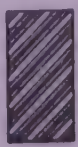


To further analyse the factors determining early marriage of the girl child, a multiple regression analysis was carried out, with the following as independent variables : the age of the woman at the time of the survey, her education, the highest educational level in her husband's family, the family's economic status, and the caste.

The educational levels were measured as illiterate, whether primary/secondary levels completed, or whether a graduate or not. The assets owned by a family, agricultural/domestic, were listed and valued, and taken as a proxy for the family's economic status. The dominant, higher and other castes were listed as high caste, and the rest as low caste.

The results are shown in Table 4. They show that while the age of the girl is important in determining when she marries, her education is an important factor in delaying the marriage.

AVERAGE AGE AT MARRIAGE OF A WOMAN BY EDUCATION IN THE WOMAN



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The present age is also positively correlated with the woman's age at marriage. This can mean the obvious in that the older she is, the more likely that she is married (or was married). But ethnographic data shows that the older a girl is, the parents are more concerned about her marriage.

It is interesting to note that caste did not matter in determining the age at marriage. The higher castes are generally more educated and aware about the external world, and it was expected that they would be marrying their girls at a later age.

Education is a known method of empowering women, and this is proved by our data. The educational status of women in our study area is given in Table 5. Although most would appear to be having only primary education, it does appear from the data that female education matters.

Apart from Gandevis, the women in other areas who married above the age of 18 yrs. were listed. These were negligible in number except in Maharashtra (181). A study of these 181 women to note their caste, education and economic class distribution was not conclusive.

3.2 Adoption of Family Planning Methods :

The adoption of spacing methods by the eligible couples was negligible in all areas (0.6% in Akole to 12.7% in Karchana. The figures for vasectomy are approximately the same.

A factor of under-reporting is possible in case of adoption of spacing methods. This is very much likely in societies like those in Railla and Karchana, where the "purdah" system is strong.

But, spacing methods were unpopular in all the study areas, because of the side-effects. The PHC services are promoting the IUD and the oral pills and both can cause side effects if improperly used.

Tubectomy / female sterilisation is the most preferred family planning method in all the area. In the male dominated societies, it has become a sort of cultural practice for families to have the desired number of children and go in for a tubectomy!

Female sterilisation rates varied from a very low 7.1% in Railla to 54.3% in Gandevi. Good extension work done by the PHCs in Garag, Gandevi and Akole are reflected in the figures. But the target of the Government of India to reach 60% Couple Protection Rate (CPR) by 2000 AD is still a long way off (Table 6).

3.3 Nutritional Status of Children Less than 5 yrs. :

High levels of malnutrition were documented in all five study areas (Figure 1). The following significant factors are associated with this data :

1. Nearly 80% of the malnourished children do not come from families with food shortages. This was reported food shortage, either seasonal or perennial (Table 7).
2. No significant gender differences in the levels of malnutrition were recorded (Table 8). Gender differences were noticeable in the sex ratios for the total populations (Table 9), and the birth of a girl child is not exactly celebrated. Considering these, it would appear that the reason for the gender differences do not lie in differential feeding for boys and girls.
3. Children in joint families were better nourished than the children in nuclear families (Table 10). Though the trend is not clearly discernible, a picture is still visible for us to conclude along there lives.

Delayed weaning, and delayed supplementation with solid feeds, was observed in all areas, common across caste and class. This resulted in growth patterns being normal till the age of 6 months, and faltering thereafter.

NUTRITIONAL STATUS OF PRESCHOOLERS IN FIVE STUDY AREAS IN INDIA, 1994

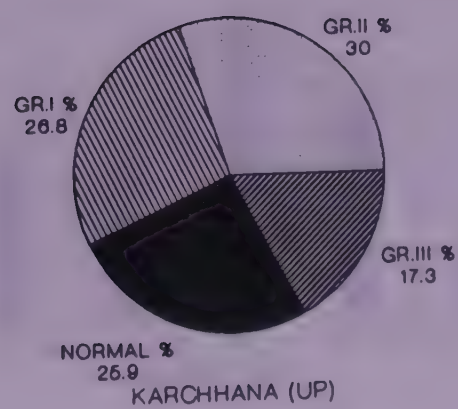
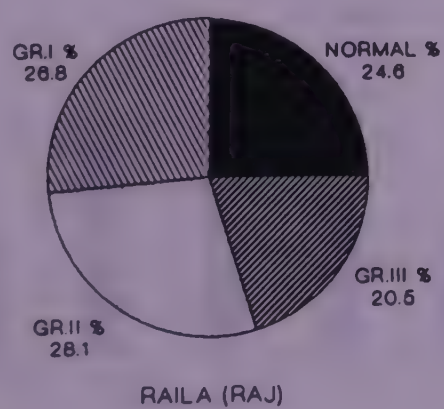
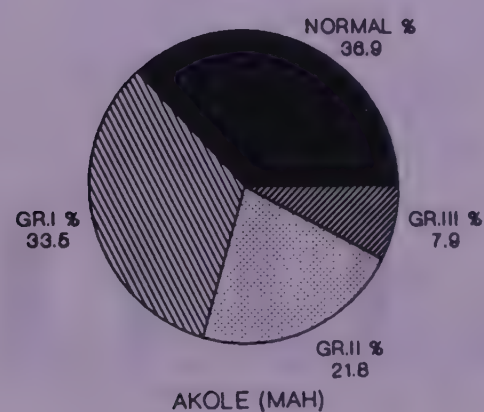
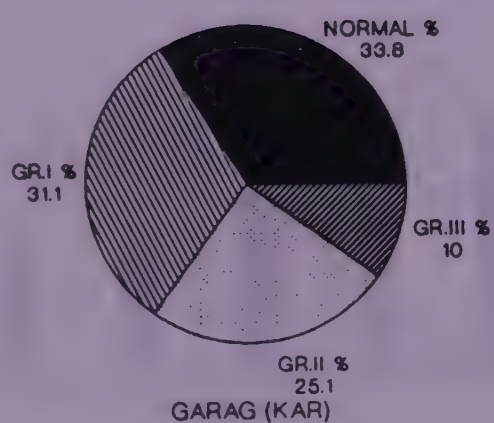
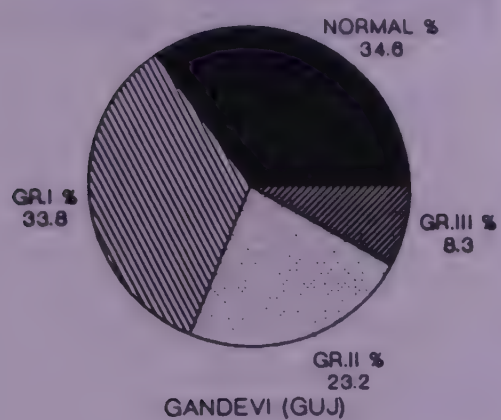


FIGURE 1

SEVERE MALNUTRITION IN BOYS AND GIRLS IN DIFF. AGE GROUPS

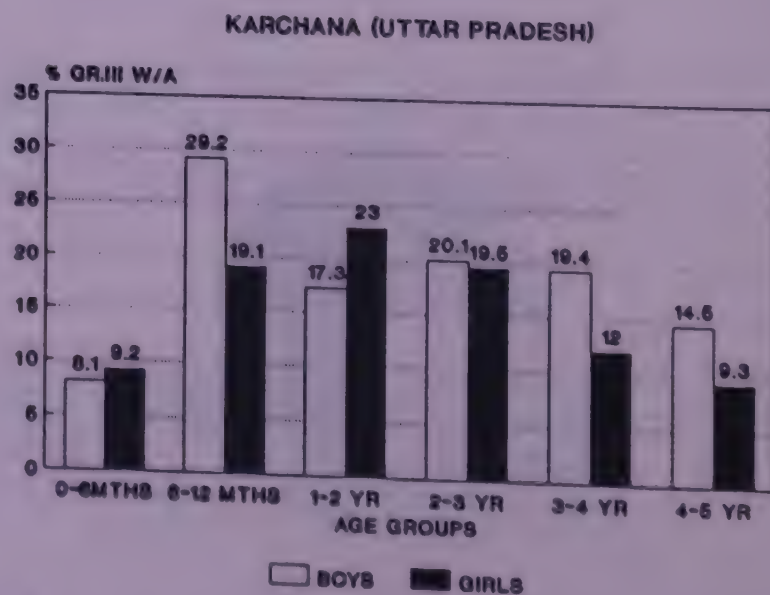
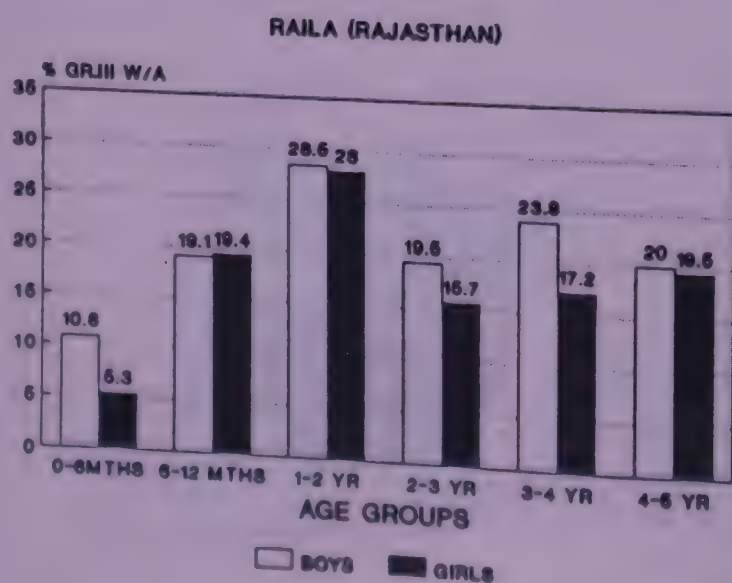
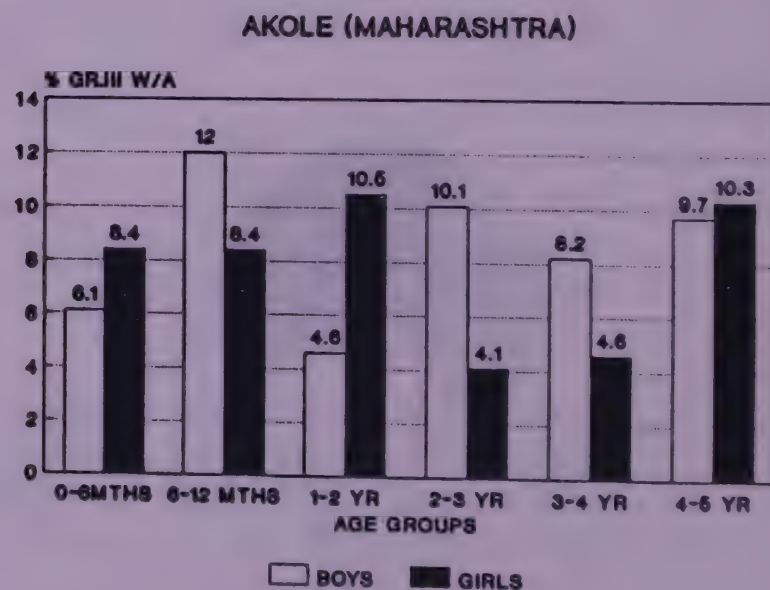
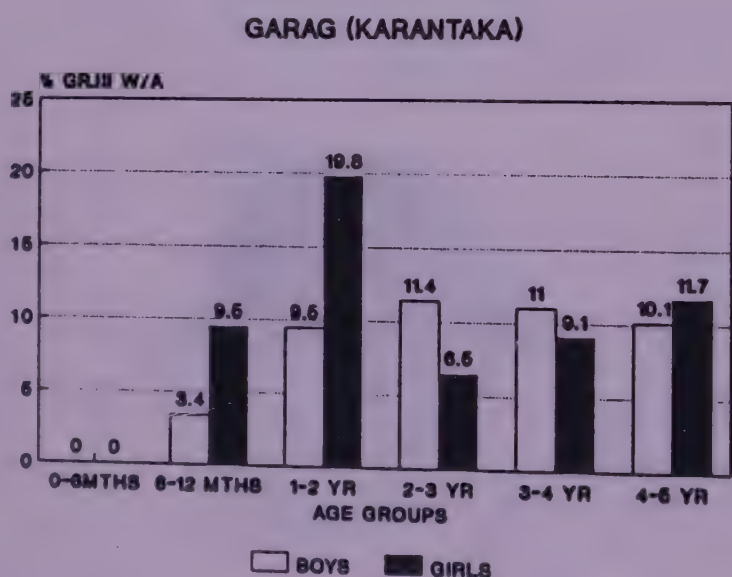
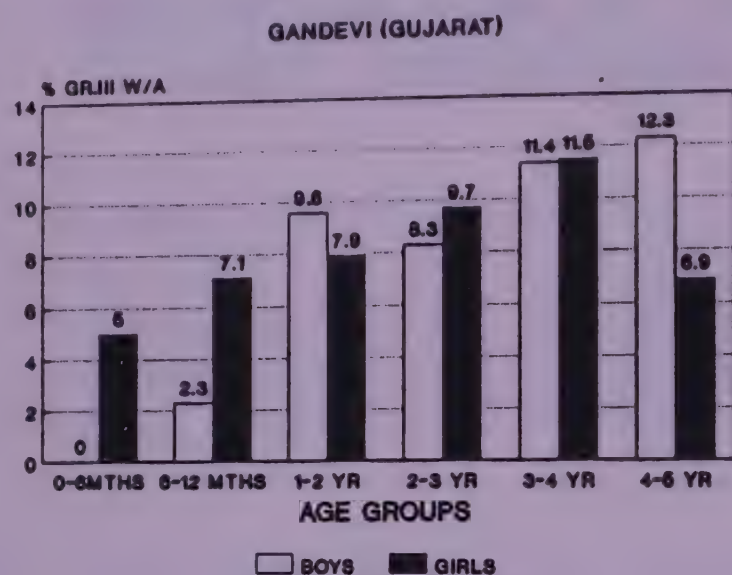


FIGURE 2

The weaning process and introduction of solid foods in a child's diet has strong cultural roots. The mother is more often than not influenced by the prevailing practices in the community, and listens to the older women in the family regarding the feeding of her children.

Joint families were earlier a part of the culture in rural India. Economic and other compulsions has led to an increasing number of nuclear families. In joint families, there are more women to care for a child, and thus the nutrition of a child is often better. In a nuclear family, especially a socio-economically backward one, care of the children is often the responsibility of an older sibling.

3.4 Ante-, Intra- and Post-Natal Care :

The pregnancy and child birth phenomena are guided by traditional beliefs and customs, and often cause majestic fuss ! In the present study, too, very limited modern care is resorted to, despite good availability and accessibility in all areas (except Rajasthan, where modern care facilities were neither easily available nor accesible).

The number of pregnant ladies and post-natal cases identified during the survey, alongwith relevant AN care and PN care data are given in **Tables 11 and 12**.

Since the numbers are very limited, resort was made to qualitative data extensively to find out the existing cultural practices and differences across castes.

A. Confirmation of Pregnancy

This is done by medically trained persons in Garag, Akole and Gandeви, especially amongst the higher castes. In Railla and Karchana, the Traditional Birth Attendant (TBA) or the elderly women in the family do it.

B. Ante-natal Care

Coverage with Tetanus toxoid injection was comparatively better in Gandevi, Akole and Garag and very poor in the other two areas (Table 11). Regular visits by the PHC workers in the first 3 states had led to a good coverage, though what the injection actually does is still unknown to the women.

Poor coverage by the PHC in Railla accounts for the poor TT coverage. In Karchana, we were told that the PHC workers are reluctant to visit the SC/OBC houses, since they themselves belong to an upper caste. The same situation accounts for the poor immunization levels among SC children in Karchana.

Iron tablets are consumed regularly by only around 25% of the pregnant ladies in all areas (Table 11). They are considered "hot" and are not popular. The Railla and Akole ladies even said that they take them weekly from the PHC staff, but feed it to the cattle at home ! The Garag women also had this fear that it may lead to a very healthy baby and thus cause problems during delivery.

Strict dietary restrictions are practiced by the women in all areas, except Gandevi. The concept of "hot" foods to be avoided exists everywhere, and the range of "hot" foods varies widely. Papaya is a common item in all lists.

The range of foods eaten by the upper castes consists of fruits, vegetables, milk and milk products, and reflects their economic capacity rather than any cultural difference from the lower castes.

However, a common belief in all areas is that pregnant women should not overeat, since very healthy babies may cause problems in delivery.

Continued work till the last day is a feature in lower caste women in all states, and is merely a reflection of their economic necessities.

Very few of the pregnant ladies complained of a health problem. Fever and bodyache is considered as an outcome of exertion during pregnancy. Similarly, swelling of the feet and face, an early sign of pre-eclamptic toxemia, is considered normal, to disappear gradually after delivery.

c. Post-Natal Care

Except in Gandevi, home level deliveries by a traditional birth attendant (TBA), is preferred in all states (Table 12). The squatting position for delivery is the preferred one. It is only in case of complications, that hospitals are resorted to.

Post-natal check-ups by a doctor / nurse is not a routine feature, unless it has been a hospital delivery (Table 12).

Women from the upper castes rest for upto 40 days, while those from the lower castes return to work after a week, reflecting the economic compulsions. The same is with foods, with nutrient-rich food like "Suthora" in Karchana, "Dinkache Ladu" in Akole, etc. being consumed by those who can afford it in the upper classes. In Railla, caste and economic compulsion may restrict the amount of clarified butter (Desi Ghee) and other food items consumed but not the tradition of having done so. A pregnant lady starts collecting money for the food items consumed after delivery.

Limited mobility outside the home for the post-natal cases for at least 15 days is the practice in all the cases. The concept of the "evil eye" exists among all castes.

Feeding of Colostrum :

Colostrum is considered as bad milk, and very few women feed it to their babies, in all states. Those who do so are women who delivered at the hospital and are advised to do so by their doctors (Table 13).

Colostrum is considered bad, since it is felt that it's not easy to digest for the baby.

One good thing in all societies is that breast feeding is continued till next pregnancy i.e. for upto 1 - 1.5 yrs.

Thus, ante-, intra- and post-natal care is determined mostly by a cultural code of conduct. Education and economy appears to have a very limited say in this matter.

3.5 Improved Water And Sanitation Facilities :

For the purposes of the study, a safe drinking water source was considered as a handpump/deep borewell. It was hypothesised that families with better socioeconomic status would have invested in getting a safe water source for their families, and a sanitary toilet.

The hypothesis could not be tested because of water resource development through other programmes. The villages surveyed have community water supplies (piped water supply in many cases), and families depend upon them to meet their needs.

There was also the paradox that the lower caste and socioeconomically backward families in Garag used handpumps more than the rest ! The reason was that political reasons had led to more handpumps being installed in the hamlets of these families ! Similarly in Rajasthan backward caste people are not allowed to fetch water from few common and all private wells so they make extensive use of handpumps.

Poor adoption of sanitary toilets, extensively documented for rural India, is a feature of these surveyed villages, too. There is a strong cultural antipathy to adopt toilets. In the Karchana area, toilets have been provided for the lower castes, again for political reasons. They are not in use.

A specific question regarding drinking water purification practices showed that very few families have resorted to chlorination or the adoption of improved filters (Table 15). The people also mentioned that they went in for boiling of water only if someone was sick in the family, and not routinely.

3.6 Traditional Medical Care

This was not planned to be collected prior to the study. However, it was observed by the anthropologists and documented.

Traditional medical practices were prevalent in all study areas to a varying extent, the least in Gandevi and the most in Railla. Table 14 gives the pattern of medical care sought for illnesses during the 2 weeks preceding the interview.

Traditional medical practitioners arose out of a need of the society, and continue to play a major role in orthodox and tradition-bound societies like the Railla area. They are often "specialists" for particular diseases, like hysteria, hepatitis and fractures.

Such practitioners are rapidly being replaced by modern medicine (a tragic circumstance, for many practices are undocumented, and a select few may be very beneficial). This was most evident in Gandevi, where modern medicine at PHCs/Private Clinics is widely available. This was evident in Akole, too, except for the settlements of tribals, called Thakarwadis. These are remote, and not easily accessible.

In Raila, another reason for the wide acceptance of traditional medicine was the bad reputation the modern medicine practitioners had earned by treating sexually transmitted diseases !

And, lastly, the cultural beliefs in traditional medicine is highlighted by cases of "Muttudosha" in Garag. This is a disease amongst children, believed to be spread by barren women. Treatment is by magico-religious practices, and the belief was found to be common across all castes. However, such children were found to be malnourished, and the related symptoms of wasting and repeated illness were believed to be "Muttudosha".

4.0 CONCLUSION & RECOMMENDATIONS :

Thus, our observations are that culture and traditions continue to play a major role in determining health behaviour in rural India. They are a stronger influence than the economic status of the families.

The health behaviour studied pertained mainly to mother and child health care. And hence there is a need to further study the influences of culture vis-a-vis economic status on other health behaviour.

More than the socio-economic status of the family, their caste, and prevailing culture and traditions in the area, explained several results of the study, especially regarding the health status and behaviour concerning mother and child health. It shows that income creates certain limiting conditions, but the dominant values, habits and norms within a particular social group determines a community's health behaviour.

Cultural/traditional norms in a society affect several aspects of health behaviour of rural families. There is now accumulated knowledge about the central role of societal determinants of health. Social class has been extensively studied, but as our study shows, health behaviour with cultural roots is often common across caste and class.

Public health has generally ignored the societal roots of health in favour of medical interventions. One reason is that there is lack of a coherent conceptual framework for analysing societal factors relevant to health. And the present public health paradigm is unclear about the directions and nature of societal change needed to promote health.

Health is a nebulous phenomenon, with several dimensions. In India, health issues of concern are communicable diseases, nutrition, and mother and child health care. In these issues, the health behavioural practices of people often explain the health status. For example, studies have shown that the nutritional status of children in some prosperous rural areas of India was poorer than in relatively socio-economically backward areas. This could be because of patterns of household spending and consumption, while being rational to the household, may not necessarily be optimal from the nutritional perspective (22).

Or, to take another example, education about simple handwashing practices after defecation in one area, decreased the incidence of diarrhoeal disorder (23).

It has been said in the relatively more traditional third world countries like India, cultural factors dominate the socio-economic factors in determining the health status and behaviour. It is only when a society attains a high level of development that socio-economic factors dominate over cultural factors. Even in the Western World, Mackenbach et al. (8) have shown that the social environment determines the individual lifestyles and risk factors and thus the health status. Their work in fact places socio-economic status further back in the causal factors determining the health status of a community.

Thus, in the present study, too, caste and cultural factors seem to be influencing health status et behavioural factors directly.

Caste is peculiar to the Indian Social Structure. It is one of the pillars in its' social organization, the 2 others being the joint family and the village community (24). Despite considerable modernizing and political forces in India, the caste structure continues to be strong in rural India and influences the "health culture" of the area, as the present study has shown.

Caste per se cannot be changed. However, the cultural factors, the traditions, which influence the health status and behaviour can be changed.

Considering the **RESULTS OF THE STUDY**, we have the following recommendations :

a. More Stress on Health Education

In the long run, only health education can overcome cultural taboos undergoing health status. Especially in the field of mother and child health care, no amount of public policy will matter unless the people are ready to accept change.

Health education programmes need to have the following specifics :-

1. They should be area specific, and culture specific;
2. They should be community-based, not community oriented, and
3. Stress must be placed on the interpersonal communication and empowerment models.

b. Continued stress on literacy

Female literacy can assist families in overcoming several cultural taboos. Since female literacy was limited in our area, its' direct effects on health behaviour has not been shown clearly, nevertheless, the ongoing literacy mission must be supported by all, esp. the health department, as an example of inter-sectoral co-ordination.

The present study has also shown that the phenomena of socio-economic status affecting health has proved to be a particularly obstinate one, to prove, and possibly remove altogether. Probably the main hurdle is culture and traditions, for which the solutions are entirely varied and different.

c. Increased use of Ethnography

Ethnography tells us why people behave the way they do. Additionally, they tell us how the behaviour of the people can be influenced. Research in health status and behaviour has to be a combination of both qualitative and quantitative data, and it is only when a qualitative picture is added that figures make sense, as this study has shown.

It is thus strongly recommended that Anthropologists be associated with the National Health Programmes. Health projects in the past have indeed taken the assistance of Social Scientists, and anthropologists have also influenced the implementation of specific health programmes.

However, our recommendation is that an Anthropologist is part of the District Health Program. He / She works the questions related to health behaviour posed by the District Health Education Officer. And while routine ethnographic techniques can be prolonged and time consuming, considerable developments have taken place in the field of Rapid Anthropological Procedures (RAP) (25), and Participatory Rural Appraisals (PRA). The latter also has the advantage of empowering communities, and developing a sense of responsibility in them to improve their health status.

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CASTE CHARACTERISTICS IN STUDY AREAS

1.0 DOMINANT CASTE :

These were the Lingayats in Karnataka, Maratha in Maharashtra, Patels in Gujarat, Rajputs and Gujjars in Rajasthan and Yadavs in Uttar Pradesh.

The term dominant caste was first coined by Dr.H.N.Srinivas (21), and is indicative of a caste numerically / politically strong in an area.

Numerically and politically, the Lingayats, the Marathas, the Patels were the dominant castes. The Rajputs and Yadavs are politically dominant. The Gujjars are numerically more. It is significant to note that the Yadavs, Gujjars and Lingayats benefit from the other backward caste (OBC) reservations of the Government of India. Economically, all are powerful.

Traditionally, they are agriculturists and own most of the village lands. The Lingayats, the Patels, the Gujjars and the Yadavs are also major livestock owners. The joint family concept is common among the dominant castes.

The Lingayats, Rajputs, Gujjars and Yadavs are still communities bound by traditions. Education is limited, especially female education. Women in Gujjar and Yadav communities are more vocal and outgoing than in the other two communities.

The Marathas and Patels, especially the latter, are forward communities. The Patels are businessmen, and migrate outside their areas. Hence, the impact of urbanisation is seen amongst them.

2. HIGHER CASTES :

This is the Brahmin community in all areas. They enjoy an advantageous position in the social hierarchy. Economically better off, education is more amongst them, they have a basic knowledge of sanitation and their personal and environmental sanitation is good. The concept of pollution and parity is found to be still very important in Uttar Pradesh and Rajasthan, and to a considerably lesser extent in Gujarat and Karnataka. The Maharashtra study area had only 5 Brahmin families.

3. OTHER CATEGORY :

This category, in all states, includes the families from other religions, like Jains and Muslims, and other Hindu castes which enjoy a better position in social hierarchy. They are generally well-off economically.

4. OTHER BACKWARD CASTES (OBC) :

These families belong to the lower middle category of the social hierarchy. They were mostly artisans at one time, and have now either continued with their occupation or shifted over to other work. These are poor families, with little education, and who generally migrate in search of work.

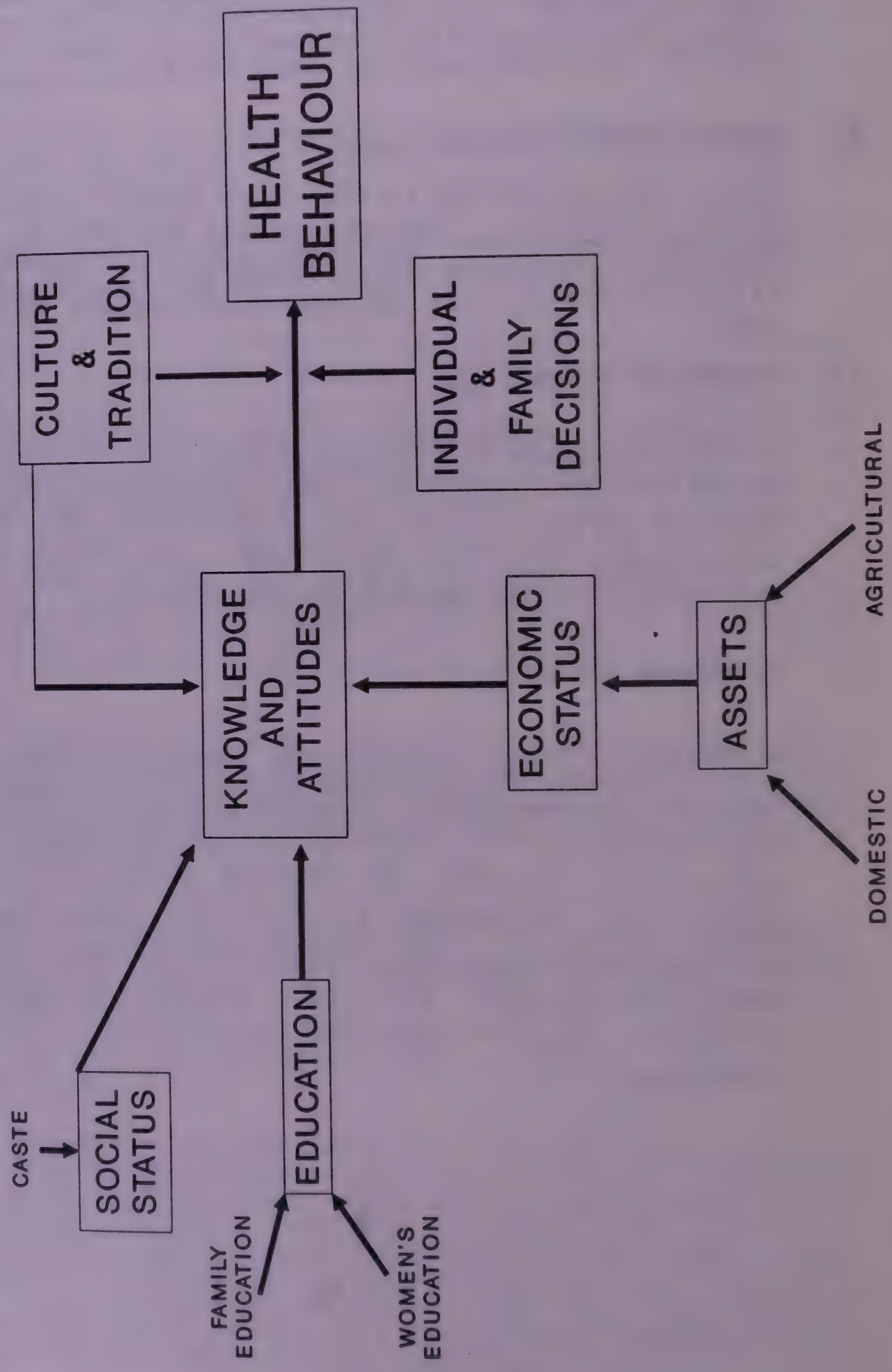
5. SCHEDULED CASTES (SC) :

The previous "untouchables" in the social hierarchy. These families continue to be the disadvantaged. The work mainly as agricultural labourers. They were found to be living in separate hamlets in all the study areas, and do not mix with the village social gatherings. The "master and slave" relationship with the higher and dominant caste was very prevalent in Uttar Pradesh and Rajasthan.

6. SCHEDULED TRIBES :

A variety of tribal communities, namely, Kolchas, Dhodias, Bhils, Thakars, Mahadev Kolis etc. were found in all areas. They are considerable in number in the Maharashtra, Gujarat and Rajasthan areas. Although staying in separate hamlets, they do not fit into the existing social hierarchy, and other enjoy a better social position than the scheduled castes, e.g. the Mahadev Kolis in Maharashtra and Dhodia-Patels in Gujarat. The Kolchas and Halpatis in Gujarat, the Thakars in Maharashtra and the Bhils in Rajasthan are among the poorest families, working as agricultural labourers, and often migrating for survival. Alcoholism is a major problem, especially because it is socially sanctioned.

INFLUENCES ON HEALTH BEHAVIOUR A CONCEPTUAL FRAMEWORK



TABLES SECTION

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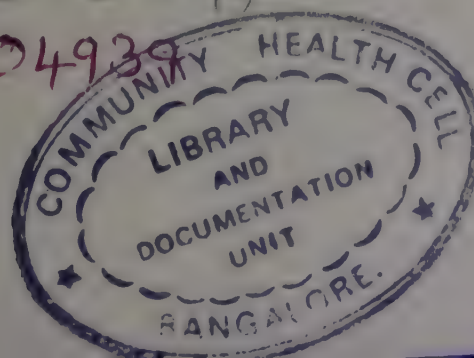


TABLE 1 : LIST OF AREAS STUDIED AND NO.OF FAMILIES SURVEYED

STATE	DISTRICT	TALUKA	VILLAGES	FAMILIES
Karnataka	Dharwad	Dharwad	12	3101
Maharashtra	Ahmednagar	Akole	15	3105
Gujarat	Valsad	Gandevi	10	3008
Rajasthan	Bhilwara	Railla	38	3107
Uttar Pradesh	Allahabad	Karchana	13	2826
TOTAL			88	

TABLE 2 : NO. OF FAMILIES IN DIFFERENT CASTE CATEGORIES IN THE STUDY AREAS

Sr. No.	Caste Category	Karna-taka	Mahara-shtra	Gujarat	Rajasthan	Uttar Pradesh
1.	Dominant	1578	1854	1000	844	112
2.	Higher	368	5	99	193	374
3.	Other	440	9	201	855	113
4.	OBC	63	351	11	312	877
5.	SC	338	123	171	559	1114
6.	ST	314	763	1526	344	12
7.	Muslim	-	-	-	-	224
	TOTAL	3101	3105	3008	3107	2826

Note :

- * Since there were very few Muslim families in all other states except UP, they have been kept in Caste Category 3 for further comparisons.
- * Since there are very few higher and other caste families in Maharashtra, they have not been considered for further analysis.

TABLE 3 : MEAN AGE AT EFFECTIVE MARRIAGE FOR ALL EVER MARRIED WOMEN IN THE STUDY AREAS

	Karnataka	Mahara-shtra	Gujarat	Rajasthan	Uttar Pradesh
No. of ever married women	5064	4760	3917	4464	3972
Mean	14.04	15.6	19.23	10.8	15.39
S.D.	3.84	2.5	2.13	4.7	2.47

TABLE 4 : FACTORS AFFECTING AGE AT MARRIAGE OF WOMEN IN THE FIVE STUDY AREAS.

VARIABLE	GARAG	AKOLE	GANDEVI	RAILA	KARCHANA
	BETA	BETA	BETA	BETA	BETA
Age	.533693*	.595482*	.702186*	.579183*	.604185*
Female Edn.	.052330*	.591489*	.064450*	.058777*	.062084*
Highest Family	.007091	.101489	-.076751	.050430	.001354
Education					
Higher Caste	-.008919	.013060	-.010970	.011912	.002996
Lower Caste	-.004528	.004668	.037605	-.023070	-.002951
Assets	-.027196	.007271	.005981	-.007717	-.025916*
Multiple R	.53388	.65434	.69410	.58487	.60578
R2	.28503	.42816	.48177	.34208	.36697
ADJ. R2	.28461	.42784	.48134	.34157	.36649
F	673.206	1303.281	1106.144	678.8572	769.650
SIG.F	.0000	.0000	.0000	.0000	.0000

* Demoted significance; $p > 0.05$

TABLE 5 : HIGHEST FEMALE EDUCATION IN FAMILIES AND MEAN AGE AT MARRIAGE IN THE STUDY AREAS

Sr. No.	Highest Female Education	KARNATAKA		MAHARASHTRA		GUJARAT		RAJASTHAN		UTTAR PRADESH	
		n	x+n	n	x+n	n	x+n	n	x+n	n	x+n
1.	Illiterate	3356	13.6 + 3.7	4690	15.6 + 2.5	1576	19. + 1.9	4339	Not	2717	15 + 2.3
2.	Primary	1333	14.5 + 3.7	65	15.6 + 2.8	1147	19 + 2.0	72	Analysed	735	15.9 + 2.4
3.	Secondary	349	15.5 + 4.2	4	16.5 + 3.1	818	19.4 + 2.2	21		165	16.7 + 2.7
4.	Graduate	24	18.2 + 5.5	1	14	376	19.9 + 2.4	4		55	19.35 + 2.4
	TOTAL	5064		4760		3917		4464		3672	

ANOVA 0.0000 0.0000 0.0000 0.0000 0.0000

TABLE 6 : ADOPTION OF TUBECTOMY BY EVER MARRIED WOMEN ACROSS CASTE CATEGORIES

SR. No.	Caste Category	KARNATAKA			MAHARASHTRA			GUJARAT			RAJASTHAN			UTTAR PRADESH		
		No.	Tub.	%	No.	Tub.	%	No.	Tub.	%	No.	Tub.	%	No.	Tub.	%
1.	Dominant	1615	795	49.2	1955	818	41.8	813	443	54.5	728	53	8	100	7	7
2.	Higher	398	180	45.2				71	30	42.2	134	10	7.5	410	99	24.1
3.	Other	436	183	41.7				171	91	53.2	905	69	8.5	92	17	18.5
4.	OBC	53	23	37.7	374	139	37.2	11	8	72.7	289	28	10.7	847	112	13.2
5.	SC	324	150	45.7	119	37	31.1	115	56	48.6	524	38	8	943	75	8
6.	ST	316	132	41.8	711	190	26.7	1242	684	55	300	8	2.6	15	3	20
7.	Muslim													192	8	4.1
	TOTAL	3142	1463	46.3	3159	1184	37.4	2423	1312	54.3	2880	206	7.1	2599	321	12.4

ANOVA = 0.000 = 0.0000 = 0.000 = 0.02 = 0.0000

TABLE 7 : ASSOCIATION OF SEVERE MALNUTRITION IN PRESCHOOL CHILDREN WITH POVERTY PARAMETERS OF FAMILY

STUDY AREA	FAMILIES REPORTING				TOTAL CHILDREN	TOTAL % GR.III
	FOOD SHORTAGE		CONSUMPTION LOAN			
	N	% GR.III	N	% GR.III		
GANDEVI (GUJ)	220	12.7	51	2	783	8.3
AKOLE (MAH)	1079	8.7	130	6.9	1402	7.9
GARAG (KAR)	268	9.7	94	20.2	1396	10
KARCHHANA(UP)	386	22.8	72	20.8	1584	17.3
RAILA (RAJ)	225	22.2	377	21.5	1146	20.5

TABLE 8 : SEVERE MALNUTRITION IN BOYS AND GIRLS IN DIFFERENT AGE-GROUPS															
AGE GROUP	GUJARAT			MAHARASHTRA			KARNATAKA			UTTAR PRADESH			RAJASTHAN		
	BOYS	GIRLS	SIG	BOYS	GIRLS	SIG	BOYS	GIRLS	SIG	BOYS	GIRLS	SIG	BOYS	GIRLS	SIG
UP TO 6 MTHS	0.0	5.0	nil	6.1	8.4	nil	0.0	0.0	nil	8.1	9.2	nil	10.8	5.3	nil
INFANTS 6-12 M	2.3	7.1	nil	12.0	8.4	nil	3.4	9.5	nil	29.2	19.1	nil	19.1	19.4	nil
ONE-TWO YR	9.6	7.9	nil	4.6	10.5	*	9.5	19.8	*	17.3	23.0	nil	28.5	28.0	nil
TWO-THREE YR	8.3	9.7	nil	10.1	4.1	*	11.4	6.5	nil	20.1	19.5	nil	19.5	15.7	nil
THREE-FOUR YR	11.4	11.5	nil	8.2	4.6	nil	11.0	9.1	nil	19.4	12.0	nil	23.9	17.2	nil
FOUR-FIVE YR	12.3	6.9	nil	9.7	10.3	nil	10.1	11.7	nil	14.5	9.3	nil	20.0	19.5	nil
TOTAL	8.2	8.4	nil	8.4	7.4	nil	9.2	10.8	nil	17.9	16.6	nil	21.9	18.9	nil

Note : * = Significance P > 0.05

TABLE 9 : SEX RATIOS IN STUDY AREAS

Sr. No.	Study Area	Sex Ratio
1.	Garag (Karnataka)	943
2.	Akole(Maharashtra)	887
3.	Gandevi(Gujarat)	987
4.	Raila (Rajasthan)	961
5.	Karchana (Uttar Pradesh)	921

INDIA (1991)

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TABLE 10 : PREVALENCE OF SEVERE MALNUTRITION BY FAMILY CHARACTERISTICS

STUDY AREA	FAMILY CHARACTERISTIC & % GRADE III W/A					% GR.III
IN STATE	NUCLEAR	JOINT	SMALL*	LARGE#	V.LARGE\$	IN TOTAL
GANDEVI (GUJ)	10.7	6.16	8.9	5.7	0	8.1
AKOLE (MAH)	7.05	8.55	7.5	8.2	7.2	7.8
GARAG (KAR)	8.66	10.3	10.1	9.7	10.3	10
KARCHHANA(UP)	21.4	12.3	20.4	16.19	12.9	17.4
RAILA (RAJ)	19.9	21.1	20.3	21.9	13.6	20.5

NOTE : * Less than or equal to five members

 # Between five to ten members

 \$ More than ten members

TABLE 11 : ANTE-MATAL CARE IN THE STUDY AREAS

Sr. No.	Study Area	TT Taken (%)	Regular Iron Tab (%)	Total ANC
1.	Garag	161 (59)	138 (51)	272
2.	Akole	91 (48)	133 (70)	191
3.	Gandevi	37 (71)	33 (65)	52
4.	Raila	7 (4)	30 (7)	175
5.	Karchana	53 (32)	35 (21)	168

TABLE 12 : POST NATAL CARE IN THE STUDY AREAS

Sr. No.	Study Area	Total PNC	Place of Delivery (%)	Visits to Docotr (%)
1.	Garag	59	49 (83)	4 (7)
2.	Akole	35	31 (89)	2 (6)
3.	Gandevi	32	15 (47)	7 (22)
4.	Raila	40	38 (95)	5 (13)
5.	Karchana	43	39 (91)	4 (9)

TABLE 13 : Feeding of Colostrum to Babies by Mothers in the Post-natal period in BAIFs study areas.

STATE	TOTAL MOTHERS IN POSTNATAL PERIOD	TOTAL MOTHERS WHO FED COLOSTRUM
KARNATAKA	76 (100%)	23 (30%)
MAHARASHTRA	57 (100%)	17 (30%)
GUJARAT	31 (100%)	17 (55%)
RAJASTHAN	41 (100%)	15 (36%)
UTTAR PRADESH	37 (100%)	17 (46%)

TABLE 14 : SICKNESS IN PRESCHOOL CHILDREN AND SEVERE MALNUTRITION								
STUDY AREA	SICK WITH DIARRHOEA				SICK WITH ACUTE RESPIRATORY INFECTION			
	% OF TOT.	NUMBER	% GR.III	%MOD. CARE	% OF TOT.	NUMBER	% GR.III	%MOD. CARE
GANDEVI (GUJ)	1.9	15	20	46.67	1.5	12	0	91.67
AKOLE (MAH)	8.6	121	11.6	64.46	13.2	185	11.4	64.86
GARAG (KAR)	4.7	65	13.8	69.23	4.8	67	9	79.10
KARCHHANA(UP)	12.8	203	24.1	70.44	15.5	245	19.6	67.76
RAILA (RAJ)	4.9	56	25	39.29	5.1	58	27.6	27.59

NOTE : % OF TOT. = PERCENTAGE OF TOTAL PRESCHOOL CHILDREN SICK

NUMBER = NUMBER OF PRESCHOOL CHILDREN SICK

% GR.III = PERCENTAGE OF SICK CHILDREN WITH GRADE III MALNUTRITION.

% MOD.CARE = PERCENTAGE OF SICK CHILDREN RECEIVING MODERN CARE

TABLE 15 : FAMILIES NOT PURIFYING DRINKING WATER IN STUDY AREAS

Sr. No.	Study Area	Total Families	Families not Purifying Water (%)
1.	Garag	3221	2606 (81)
2.	Akole	3156	2663 (84)
3.	Gandevi	3037	965 (32)
4.	Raila	3089	1387 (45)
5.	Karchana	2890	2130 (74)

THE BAIF MISSION

BAIF's mission is to create opportunities of gainful self-employment for the rural families, especially disadvantaged sections, ensuring sustainable livelihood, enriched environment, improved quality of life and good human values.

This will be achieved through development research, effective use of local resources, extension of appropriate technologies and upgradation of skills and capabilities with community participation.

BAIF is a non-political, secular and professionally managed organisation.



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